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CALIFORNIA MEDICAL ASSISTANCE COMMISSION

State Capitol, Room 2040

Sacramento, CA

Minutes of Meeting

May 27, 2004

COMMISSIONERS PRESENT
Nancy E. McFadden, Chair
Thomas Calderon
Diane M. Griffiths
Teresa P. Hughes
Vicki Marti
Michael R. Yamaki

CMAC STAFF PRESENT
J. Keith Berger, Executive Director
Enid Barnes
Theresa Bueno
Denise DeTrano
Holland Golec
Vanessa Guerrero
Mervin Tamai
Karen Thalhammer
Donald Wooten, Ph.D.

COMMISSIONER ABSENT
Lynn Schenk

EX-OFFICIO MEMBER PRESENT
Stan Rosenstein, Department of Health Services

EX-OFFICIO MEMBER ABSENT
Chantele Denny, Department of Finance

I. Call to Order

The open session meeting of the California Medical Assistance Commission (CMAC) on May 27, 2004 was called to order by Chair Nancy E. McFadden. A quorum was present.

II. Approval of Minutes

The May 13, 2004 meeting minutes were approved as prepared by CMAC staff.

III. Executive Director's Report

The Executive Director, Keith Berger, indicated that there were no new requests from hospitals or health plans to appear before the Commission in closed session at this time.

Mr. Berger noted that there are 22 amendments before the Commission for action in today's closed session, and that CMAC is close to completing this round of the SB 1255 program. He also indicated that Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services (DHS) will be joining the Commission later to update the Commission on Medi-Cal related issues and the May Revise to the coming year's budget.

Keith Berger reported that in the May Revise, the California Department of Corrections (CDC) is exploring the option of using Medi-Cal rates to establish reimbursement levels for a variety of medical providers under their program. CMAC staff is working with CDC, DHS, the Department of Finance, and legislative staff develop language that assures that if that option is pursued the confidentiality of CMAC negotiated rates and other contract information is protected.

IV. Medi-Cal Managed Care Activities

The Executive Director informed the Commission that the Health Plan of San Mateo voted to approve an amendment to extend their contract through December 31, 2004. This will give everyone another six months to continue working through the financial issues facing the plan.

V. Appearance by Los Angeles County, Department of Health Services

Dr. Thomas L. Garthwaite, Director and Chief Medical Officer; Fred Leaf, Chief Operating Officer; and Gary Wells, Chief Financial Officer of the Los Angeles (LA) County Department of Health Services, appeared before the Commission at the request of the Commissioners to provide an update regarding the Los Angeles County Health Department's latest budget projections.

Dr. Garthwaite stated that in June 2002, the LA County Board of Supervisors approved a strategic plan that calls for service reduction and efficiencies, which are targeted to progressively produce $357.5 million in annual net operating savings by FY 2005-06. These significant reductions pale in comparison to the reductions the county would have had if they did not get some substantial relief from Measure B and the recent terms of the federal and state Selective Provider Contracting Program (SPCP) waiver. LA County continues to be enjoined by the courts from reducing or closing Rancho Los Amigos National Rehabilitation Center and from reducing beds at USC Medical Center. The trial dates for those actions are February 2005 for Rancho Los Amigos and April 2005 for USC Medical Center bed reductions.

Dr. Garthwaite indicated that the current forecast anticipates a $740 million cumulative shortfall through the FY 2007-08, with $309 million of that expected to occur in FY 2006-07. He also noted that other possible events not included in the current estimate, such as the inability to close or transfer Rancho Los Amigos and to reduce USC Medical Center beds by 100, could increase the potential cumulative year-end fund balance/shortfall to an estimated $1.6 billion. Dr. Garthwaite describe a number of other factors that continue to contribute to LA County's projected shortfall.

In response to Commissioner Calderon's comments and question, Gary Wells, Chief Financial Officer, and Dr. Garthwaite discussed ways in which the state and counties could work together to increase federal funding for Medicaid and California.

Dr. Garthwaite reported that LA County continues to pursue fundamental redesign of their system and is making good progress on a number of fronts. He listed new policies and initiatives related to patient transfers, patient safety, quality of care, performance management, mental health care, information systems, and group purchasing.

Regarding Martin Luther King/Drew Medical Center (MLK), Dr. Garthwaite indicated that there has been a significant improvement in the hospital and that he hopes to restore the training programs and to regain public confidences in the institution.

In concluding his update report, Dr. Garthwaite thanked the Commission for their generous support to the LA County system throughout the years.

Commissioner Hughes commented that she was very happy to hear that MLK is doing better.

Dr. Garthwaite indicated that the endowment has funded a steering committee that is chaired by Dr. Hopper, retired Vice President of Health Affairs for the University of California (UC) system. He is providing very good guidance in helping the board of directors for MLK deal with some very difficult issues. In addition, the current Vice President for Health Affairs at UC, Dr. Michael Drake, is overseeing a committee that is looking at graduate medical education.

Mr. Leaf indicated that in December 2003, MLK was on the brink of total meltdown. Since then he said MLK has come a long way. During the first part of May 2004, MLK had a Joint Commission on Accreditation of Healthcare Organization (JCAHO) survey. He said they received full accreditation with no special provisions; only a few items need attention, and will be addressed. He further noted that last week, MLK was visited by representatives of the federal Centers for Medicare and Medicaid Services (CMS). A full scope survey was conducted and MLK passed 21 of 23 conditions.

In response to several questions asked by Commissioner Griffiths, Dr. Garthwaite indicated that LA County has never contemplated the closing of MLK. Mr. Leaf remarked that the two areas about which CMS had concerns were the number of nurses (primarily in the psychiatric area) and that patient assessments were not being completed in a timely manner.

Mr. Wells indicated that the current LA County 1115 Waiver expires June 30, 2005. He indicated that, rather than focus on the extension of that waiver, the strategy has been to cooperate with the California Association of Public Hospitals (CAPH) in developing a proposal that is being called "Cal Access." That proposal would establish a demonstration project to increase the coordination of care in public hospitals with other resources in the community and capitalize on funds such as realignment funds, which currently are not matched by Federal Medicaid dollars.

Mr. Wells indicated that LA County has had a conference call with Secretary Kim Belshé, Stan Rosenstein, and others, to walk them through the proposal and to answer their questions. When the proposal was drafted, the goal was to try to increase Medicaid funding, and that LA County is continuing to work with the state to explore other opportunities as well.

VI. Health Facility Planning Area 411 Access Issues

Executive Director Keith Berger introduced Mitchell Zack, Vice President, John Muir/Mt. Diablo Health Systems, to the Commission and informed the Commissioners that several non-contract hospitals had requested to appear before the Commission to ask for consideration and action related to Health Facility Planning Area (HFPA) 411, which is in Contra Costa County. Mr. Berger indicated that CMAC staff had just completed an initial analysis of some of the key issues. He offered to go over that analysis after the hospitals had made their presentation.

Mr. Zack introduced Becky Levy, Chief Financial Officer from Sutter Delta Medical Center and Josephine Wong, RN, Case Manager Supervisor, Quality Management Department of Sutter Delta Medical Center, to the Commission and public.

Mr. Zack informed the Commission that they were here today to ask the Commission to declare HFPA 411 an open area pursuant to the lack of sufficient contracted bed capacity under the Selective Provider Contracting Program (SPCP) federal waiver and to address the impact of travel times on Medi-Cal beneficiaries. More specifically, he said, the State's requirement to transfer hospitalized patients in non-contracting hospitals to contracted hospitals in the HFPA is not feasible because he believed that none of the contracting facilities are within state and federal travel times and distances.

Mr. Zack further indicated that for over two years there has been only one contracting hospital in HFPA 411, Contra Costa Regional Medical Center (the County), and that it has no capacity to accept transfers. He said this has been documented and confirmed by the Medi-Cal field office and that difficulties with access to quality care in the HFPA 411 have been acknowledged by both CMAC and DHS as far back as October 2001, in a letter from DHS. Mr. Zack remarked that they have taken a number of steps to request CMAC to act upon this issue, including providing documentation on travel times and access issues. The non-contract hospitals

believe that opening the area will facilitate timely access to care and thus enhance medical outcomes and the overall health of this population.

Mr. Zack then provided some background information on the Contra Costa area including distribution of Medi-Cal beneficiaries and the mission and goals of the John Muir/Mt. Diablo Health System.

Mr. Zack closed by stating that they are here to formally ask CMAC and DHS to make a determination of insufficient capacity to meet the needs of the beneficiaries in HFPA 411 pursuant to Welfare & Institutions Code, Section 14081.

Commission Chair Nancy McFadden asked if the other hospital representatives had anything they wanted to add.

Ms. Levy indicated that Sutter Delta is also committed to providing quality health care. Ms. Levy informed the Commission that Sutter Delta is located in Antioch and that it has experienced a lot of growth in the Medi-Cal and indigent populations in their community, with a resulting growth in utilization at the hospital, especially in the emergency room.

Commissioner Calderon remarked that when the Commission discusses hospital terminations in a particular area, there is always the concern that the termination will result in increased expenditure. He asked why the hospitals thought that opening this area wouldn't cost the State more money. He also asked the hospitals why they were not contracting with the State.

Mr. Zack replied it is not a financial issue for the hospitals but, instead, an access issue for the community. He said he felt it placed a great burden on patients and their families to not be able to get inpatient care where they lived.

Commissioner Calderon remarked that if the area is opened then the non-contract hospitals could treat additional Medi-Cal patients and be paid higher rates than the State is currently paying for that care. Therefore, it seemed to him that some of the hospitals' motivation was financial and that if it was strictly an access issue then the hospitals would contract with the State.

Hrant Kouyoumdjian, a consultant for the non-contract hospitals, joined them at the table and responded to Commissioner Calderon's remarks. He said the real issue is the burden that is being placed on the DHS field office as well as the hospitals and families to try and find transfers when no transfers are available. He said he believes that the County has claimed for years to CMAC staff that they have bed capacity and CMAC has assumed, based on the county's claims, that capacity exists.

Mr. Kouyoumdjian stated that the non-contract hospitals have documented the calls that have been made to the County to request a patient transfer and that not a single transfer occurred in 2002 or 2003. He said the process of attempting to transfer, documenting that no transfer

could be made, and the related uncertainties that process produces is not good quality care and is a burden on the field office, the patients, their families, and the hospitals.

Commissioner Calderon's opinion was that it is somewhat disingenuous for the hospitals to come to the Commission and say they are concerned about access and yet not be willing to discuss the possibility of negotiating a contract because they don't want to be paid less. He understands they have costs and that as part of hospital systems they have financial targets to meet, but he sees the issue as bigger than how much time it is taking to get to a certain hospital.

Commissioner Calderon said that his position is that the problem can be solved by the hospitals having a contract and that CMAC is more than willing to sit down and negotiate.

Mr. Kouyoumdjian expressed disagreement with Commissioner Calderon's assumption that opening the area would cost the State money. He said that since no transfers have taken place for two years, there have been no additional costs or cost savings [over what would have taken place if the area was open]. Mr. Kouyoumdjian also commented on the initial capacity/need analysis prepared by CMAC staff and provided to the hospitals and Commissioners at the meeting. He expressed concerns about the methodology and data sources used.

Commissioner Calderon said that the transfers and related transportation issues are valid and could probably be worked out if we sat down with the County and discussed it further. Mr. Kouyoumdjian stated that the SPCP Waiver has a requirement that the program will not substantially impair access to care and services of adequate quality and also commented that it may be appropriate to talk with the County to determine why they aren't accepting transfers.

Stan Rosenstein of DHS asked for clarification as to what the problem is that we are attempting to solve, if all of the patients are receiving care. He said the testimony has indicated that the DHS field office is appropriately approving inpatient Treatment Authorization Requests (TARs) when there are access issues (if not, Mr. Rosenstein asked to be so informed). He further questioned that in light of the fact that the non-contract hospitals are being allowed to see those patients and receive the non-contract rate, that apparently no transfers are occurring and therefore none of the non-contract hospital patients have had to travel to the county hospital, how there could be a serious access problem.

Mr. Zack responded first by saying that DHS has been very helpful in working with the hospitals. Mr. Zack clarified that the patients getting care at their hospitals are emergency or trauma patients. He said the hospitals are not getting any elective referrals. Mr. Zack said the main access issue, in his opinion, is not with emergency or trauma patients, it is with patients who are having elective procedures. Those TARs are not being approved because his hospitals are non-contract facilities in a closed area.

Ms. Wong said she wanted to return to the quality issue. She said that in April of this year the County, for a period of time, was active in accepting transfers. She said that there were seven transfers in a two-week period. The largest concern for Ms. Wong related to those seven

transfers was the difficulty of assuring continuity of care and the transportation issues for the patients' families.

Mr. Kouyoumdjian asked to respond to Mr. Rosenstein's question about what problem needs to be solved. He stated that there are also some problems with the DHS field office due to staff turnover and workload issues. He said that there are inappropriate TAR denials and that having to then process a lot of unnecessary TAR appeals is taking a lot of state staff time.

Mr. Rosenstein said the data from his field office operations staff shows very few TAR appeals occurring in the Contra Costa area. Ms. Wong clarified that the confusion is usually resolved at the San Francisco field office level and that these do not become official appeal cases sent to Sacramento.

Commissioner Griffiths stated that CMAC's actions over the last 20 years indicate the Commission is concerned about access issues and that the State has done a good job of assuring access to inpatient care for Medi-Cal beneficiaries. She suggested that the staff be given some time to investigate the situation and that the Commission address the issues again when more information is available.

Commission Chair Nancy McFadden agreed, thanked the hospitals for their comments and asked staff to follow up on the issues raised and report back to the Commissioners in a month.

Chair McFadden asked Mr. Stan Rosenstein to delay his update to the Commission on Medi-Cal Redesign and the May Revise until open session is recommenced after today's closed session.

VII. New Business/Public Comments/Adjournment

There being no further new business and no additional comments from the public, Chair McFadden recessed the open session. After the closed session, the Commission reconvened in open session. Chair McFadden announced that the Commission had taken action on hospital contracts and managed care amendments in closed session.

Now being in open session, Chair McFadden requested that Stan Rosenstein, Department of Health Services, give a brief overview to the Commission on Medi-Cal Redesign issues.

Mr. Rosenstein reported that California has three intergovernmental transfer programs that are under close review by the federal government: The LA County Waiver, the Disproportionate Share Hospital (DSH) program, and the SB 1255/GME program. The federal government does not favor intergovernmental transfers (IGT) that involve what they call recycling of dollars. As California uses IGTs; in its program, California is one of the states that is under the microscope.

Mr. Rosenstein stated that the federal government has hired 100 new auditors nationally to review this issue, and six of these auditors are in California looking at the source of funds for IGTs. Mr. Rosenstein stated that the federal government wants to phase out IGTs and that seven states have already been asked to phase out their IGT programs as of June 30, 2005. The President has tried to eliminate IGTs in Congress, but has not been successful to date.

Mr. Rosenstein further informed the Commission that the submittal of the SPCP Waiver renewal is due in September 2004, and the SPCP Waiver includes $900 million that are generated through IGT programs. Mr. Rosenstein said there should be no doubt in anyone's mind that if the submitted SPCP Waiver is the same as the current waiver, it is going to raise IGT funding issues.

Mr. Rosenstein indicated that DHS is looking into an alternative funding structure that takes all of the county and UC monies that are in the Medi-Cal system and uses those funds for the federal match as certified public expenditures, to try to substantially remove the state from the IGT process. DHS presented this alternative to the hospital associations and is trying to have them approve a concept that significantly reduces the state's reliance on IGTs. DHS is looking for an option to show the federal government that the state wants to forego IGTs and to discuss ways to enhance funding.

Mr. Rosenstein reported that under the current programs, hospitals are capped out. There is no more DSH money coming, SB 1255 is declining, the FMAP is reduced on July 1, and the state is in its third year of a declining UPL transition phase. At best under the status quo, the state is going to have less money next year than it had this year. He said we have to find other ways of financing that can allow costs and reimbursements to grow.

In response to Chair McFadden's question, Mr. Rosenstein replied that there are a couple of issues that bring California to place 51st in federal funding. Years ago, California made the decision to control Medi-Cal funding by how much general fund is appropriated. Medicaid gives California 50 percent federal money so if the state pays large amounts, we bring in large amounts of federal funds. California wanted to save general fund so it was willing to lose some federal funds. Another issue is that the state has put a lot of effort into being an efficient program. When it is said that California is the lowest ranked per capita, it is because we cover a lot of people. When one looks at per-resident expenditures, we are close to the middle. We are still low in expenditures compared to the tax base, but California has made it a priority to cover more people.

Mr. Rosenstein reported that the Governor has been very clear that he wants to redesign the Medi-Cal program. Medi-Cal has grown by 40 percent in general fund expenditures in the last five years. At this growth rate, the program is unaffordable for the state in the long term. The Governor does not want to cut eligibles and he does not want massive benefit reductions. Mr. Rosenstein indicated that DHS is working on a reform effort that will look at cost controls that keeps people eligible, but that brings in some of the elements from private insurance and other states--that includes potential cost sharing premiums, co-pays, expanding managed care, redefining the eligibility system, and hospital reform.

Mr. Rosenstein stated that DHS has staff working on the SPCP waiver submission. Before September he said, we need to decide if the SPCP waiver should be submitted as is delaying approval while we continue the discussion of the IGTs, or do we want to come forward with something that we think is more stable? DHS is in discussion now with the hospitals, but DHS cannot project the outcome of these discussions at this time.

There being no further business, Chair McFadden adjourned the open session.